Authorization to Release Medical Information
Dillon Office 41 Barrett Street
Dillon, MT 59725
Telephone: (406) 683-4440
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PLEASE PRINT CLEARLY

Patient Name:_____ Birth Date:_____

Other Name (i.e. maiden name)_____

Address:_____ Phone: _____

- I authorize the Southwest Montana Community Health Center to _____**RELEASE** copies of information from my medical record to:
- I authorize the Southwest Montana Community Health Center to _____**RECEIVE** copies of my medical record from:
- I authorize the Southwest Montana Community Health Center to _____ **DISCUSS** my medical condition with:

SEND TO/RECEIVE FROM :_____PHONE NUMBER:_____
STREET ADDRESS: _____
CITY, STATE & ZIP CODE:_____

The purpose of this release is for: _____Diagnostic Evaluation _____Transfer of Care
_____Other (Please specify)_____

Records to be released:

____Progress Notes ____Lab Reports ____X-ray reports _____ Medication Record ____ Physician Orders/Notes
____Nursing Notes _____Other (Please specify)_____
DATES OF SERVICE: FROM:_____ TO:_____

I understand that my records may be protected under Federal Confidentiality Regulations and cannot be disclosed without my signed consent unless as otherwise provided in the aforementioned regulations. I give special permission to release any information regarding **(check box and sign on line(s) below that you grant us permission to release the information to the above).**

_____ **Substance Abuse:** **Signature** _____
_____ **Psychiatric/Mental Health** **Signature** _____
_____ **HIV Status** **Signature** _____
_____**STD** **Signature** _____

- I understand that once this information is disclosed, the information is subject to re-disclosure and may no longer be protected by the Federal Privacy Regulations.
- I understand that I may revoke this consent—**IN WRITING**—at any time except to the extent that action has been taken in reliance thereon.
- I understand that this office does not release records from other medical providers and that it is my responsibility to obtain records from other medical providers.
- I understand that this authorization will automatically expire 12 months from the date signed or earlier if revoked by me in writing.

SIGNED:_____ DATE:_____
(If signed by representative for patient, please indicate relationship)

WITNESS:_____ DATE:_____

Reviewed 09-22-14